Annual Hospital Financial Survey: Parts A-F

Georgia Department of Community Health

Part A: General Information

Facility UID:

Year:

UID:

Facility Name:

County:

Street Address:

Mailing Address:

Report Period: **Please report data for the hospital fiscal year ending during calender year 2006 only.**

Please indicate your hospital fiscal year. through

Please indicate your cost report year. through

Check the box to the right if your facility was not operational for the entire year ☐

If your facility was not operational for the entire year , provide the dates the facility was operational below:

Part B: Contact Information

Contact Person: **Title:**

Telephone: **Fax:** **E-mail:**

Part C: Financial Data and Indigent and Charity Care

Please report the following data elements. Data reported here must balance in other parts of the HFS.

Revenue or Expense	Amount
1a. Inpatient Gross Patient Revenue	
1b. Total Inpatient Admissions accounting for Inpatient Revenue	
2a. Outpatient Gross Patient Revenue	
2b. Total Outpatient Visits accounting for Outpatient Revenue	
3. Medicare Contractual Adjustments:	
4. Medicaid Contractual Adjustments:	

Revenue or Expense	Amount
5. Other Contractual Adjustments:	
6. Hill Burton Obligations:	
7. Bad debt:	
8. Uncompensated Indigent Care (net):	
9. Uncompensated Charity Care (net):	
10. Other Free Care:	
11. Other Revenue/Gains:	
12. Total Expenses:	

Part D: Indigent/Charity Care Policies and Agreements

1. Did the hospital have a formal written policy or written policies concerning the provision of indigent and/or charity care during ?
2. What was the effective date of the policy or policies in effect during ?
3. Please indicate the title or position held by the person most responsible for adherence to or interpretation of the policy or policies you will provide the department.
4. Did the policy or policies include provisions for the care that is defined as charity pursuant to HFMA guidelines and the definitions contained in the Glossary that accompanies this survey (i.e., a sliding fee scale or the accomodation to provide care without the expectation of compensation for patients whose individual or family income exceeds 125% of federal poverty level guidelines)?
5. If you had a provision for charity care in your policy, as reflected by responding yes to item 4, what was the maximum income level, expressed as a percentage of the federal poverty guidelines, for a patient to be considered for charity care (e.g., 185%, 200%, 235%, etc.)?
6. Did the hospital have an agreement or agreements with any city or county concerning the receipt of government funds for indigent and/or charity care during ?

Part E: Indigent And Charity Care

Please indicate the totals for indgent and charity care for the categories provided below. If the hospital used a sliding fee scale for certain charity patients, only the net charges to charity should be reported (i.e., gross patient charges less any payments received from or billed to the patient.) Total Uncompensated I/C Care must balance to totals reported in Part C.

	Indigent Care	Charity Care	Indigent/Charity Care Provided
1. Inpatient			
2. Outpatient			

Gross I/C

Source of funding	Amount
3. Home County	
4. Other Counties	
5. City Or Cities	
6. Hospital Authority	
7. State Programs And Any Other State Funds (Do Not Include Indigent Care Trust Funds)	

Source of funding	Amount
8. Federal Government	
9. Non-Government Sources	
10. Charitable Contributions	
11. Trust Fund From Sale Of Public Hospital	
12. All Other	

Total Compensation for I/C Care

Uncompensated I/C Care

Part F: Total Indigent/Charity Care By County

Inp Ad-I = Inpatient Admissions (Indigent Care)
Inp Ch-I = Inpatient Charges (Indigent Care)
Out Vis-I = Outpatient Visits (Indigent Care)
Out Ch-I = Outpatient Charges (Indigent Care)

Inp Ad-C = Inpatient Admissions (Charity Care)
Inp Ch-C = Inpatient Charges (Charity Care)
Out Vis-C = Outpatient Visits (Charity Care)
Out Ch-C = Outpatient Charges (Charity Care)

Total Inpatient Admissions (Indigent Care)

Total Inpatient Charges (Indigent Care)

Total Outpatient Visits (Indigent Care)

Total Outpatient Charges (Indigent Care)

Total Inpatient Admissions (Charity Care)

Total Inpatient Charges (Charity Care)

Total Outpatient Visits (Charity Care)

Total Outpatient Charges (Charity Care)

Hospital Financial Survey Signature Form

Georgia Department of Community Health

Electronic Signature(s)

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omited data could lead to sanctions against me or this facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Chief Executive: _____ Date:

Title: _____

I hereby certify that I am the financial officer authorized to sign this form and that the information is true and accurate. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Signature of Financial Officer: _____ Date:

Title: _____

Comments: _____

Calculated Totals:

The following totals are calculated from the reported information in the 2006 HFS. You may click on the category name in blue for a definition of the term.

Financial Statistics	Indigent and Charity Care Statistics
Gross Patient Revenue:	Reported Uncomp Indigent/Charity Care:
Total Deductions from Patient Revenues:	Adjusted Gross Revenue:
Net Patient Revenue:	Reported Indigent/Charity Care as % of AGR:
Total Revenues:	
Total Net Revenues:	
Total Expenses:	
Margin:	
Margin Percent:	
Cost to Charge Ratio:	